



**BEFORE THE  
FEDERAL COMMUNICATIONS COMMISSION  
WASHINGTON, D.C. 20554**

In the Matter of:

Notice of Proposed Rulemaking (NPRM)	)	
Regarding the Universal Service Support Mechanism	)	WC Docket 02-60
For Rural Health Care	)	

**Comments of the Nebraska Statewide Telehealth Network Governing Committee**

**About the Nebraska Statewide Telehealth Network**

The Nebraska Statewide Telehealth Network (hereinafter referred to as the NSTN) Governing Committee thanks the Federal Communications Commission (Commission) for the opportunity to comment on the NPRM Regarding the Universal Service Support Mechanism for Rural Health Care.

The NSTN is a collaboration of over 100 hospitals, health departments, mental health centers and rural health clinics with the mission of:

- Increasing the quality, availability and accessibility of healthcare throughout the state by maintaining and promoting a secure communication network that allows rural areas of the state to have access to other healthcare providers and information without the need for extensive travel.
- Bringing together invaluable resources to improve the healthcare readiness of the state to respond to terrorist acts and threats as well as naturally-occurring disasters.

The NSTN exists to serve rural Nebraska, a state with a total population base of 1,796,000 individuals, 44% of whom reside in two of the state's 93 counties. Nearly 80% of the health care sites in the NSTN are currently eligible to receive USF support through the FCC Rural Health Care Program, which has amounted to over \$7.8 million in funding from FY2002-2008 (according to the NPRM released, this makes Nebraska the fourth highest state in terms of RHC disbursement).

As with many telehealth programs across the nation, the NSTN's number one priority is long-term sustainability. The FCC Universal Service Support Mechanism for Rural Health Care is key to that sustainability.

**Comments Regarding the NPRM Released July 15, 2010**

The NPRM released by the Commission on July 15, 2010 is extensive and many across the nation, especially those involved with the current FCC Pilot Program, are well-qualified to comment in-depth on most items contained within the Notice. The NSTN Governing Committee

has prioritized only those items that are of most concern to the NSTN at this time; we do not present this document as inclusive of all changes that may be needed.

The NSTN's comments are organized, as follows:

- I. Comments Regarding the Proposed Health Infrastructure Program
- II. General Comments Regarding the Rural Health Care Program

Those items in **bold** are taken from the NPRM with the NSTN Governing Committee's comments following in *italics*.

## **I. Comments Regarding the Proposed Health Infrastructure Program**

### **Demonstrated Need for Infrastructure Funding**

**We propose that applicants under the health infrastructure program demonstrate that broadband, at the connectivity speeds defined below, is presently unavailable or insufficient for health IT needed to provide or improve health care delivery requested by the eligible health care providers seeking funding.**

*The NSTN Governing Committee is concerned that the proposed process requiring the applicant to provide proof of broadband underserved areas through extensive mapping studies will be both difficult and costly to accomplish. The NSTN Governing Committee believes that studies with sufficient detail to provide this information do not currently exist. In addition, the availability of "broadband capabilities" needs to have further definition. For example, if one small area in a county has access to broadband capabilities at the speed denoted in the application, does that determine that the entire county has sufficient broadband capabilities? Additionally, is the cost of such service considered in the definition of coverage? If an area has the technical capability of providing the service but at a cost that is not affordable to the potential users, does that indicate true availability and accessibility of service?*

*Pre-application verification of no or insufficient broadband accessibility puts an undue burden on the applicant and requiring a six-month posting period to prove that no telecommunications carrier can provide requested services creates an application process that is overly lengthy and does not help networks move forward in serving our communities. It is understandable that the Commission wants to ensure that the applicant is not wasting funds duplicating what already exists, but assistance from the Commission in identifying suitable complete studies that have already been done and a more reasonable posting period would seem to be more appropriate.*

### **Letters of Agency**

**We propose that as part of the initial application phase for infrastructure projects, applicants identify (1) all eligible health care providers on whose behalf funding has been sought...In addition, as in the Pilot Program, we would require that the application include a Letter of Agency (LOA) from each participating health care provider, confirming that the health care provider has agreed to participate in the applicant's proposed network...**

*While the NSTN Governing Committee understands the Commission seeks to ensure that the applicants funded truly represent their constituents and have sufficient buy-in and dedication of their partners to successfully deploy the project, it would be difficult for a health care provider to commit to a long-term project when costs have not fully been identified and will not be identified until the planning process is complete, especially in light of the fact that likely participants will be small, rural health care facilities with small operating budgets. The NSTN Governing Committee suggests that Letters of Intent would be appropriate and would allow for changes that may occur if agencies determine that they cannot be part of the project or if other agencies are deemed appropriate to join the project after award.*

## Funding Requests and Budgets

*In this section of the NPRM, the Commission seeks comment both on the number of projects that should be awarded annually and the amount of funding that could be awarded to each project.*

*As the NPRM posits (Notice of Public Rule Making, July, 2010, pp 2), “The greater broadband connectivity has the potential to revolutionize health care delivery by providing access to state-of-the-art Health IT solutions to over 12,000 hospitals and clinics across the nation...Use of health-related applications delivered over broadband will not only save lives, but also cut costs by shortening average hospital stays, reducing the need for tests, and increasing administrative efficiencies”. If the Commission supports this concept, then all efforts should be made to award funding to applicants striving to make this hypothesis a reality. If there is concern that USAC cannot adequately coach awardees, then all efforts should be made to provide USAC the tools, personnel and other resources necessary, including a reduction in administrative burden, for them to serve participants effectively. USAC limitations should not limit the future of health care progress.*

*Secondly, with regard to imposing a cap on the amount funded per project, many valuable projects that will yield a high return on investment and help the greatest number of people may be the most expensive to deploy, especially in states like Nebraska with large, rural land masses. The actual cost of development and implementation of a project should be judged by the return on investment including the value provided to potential users, not predetermined by a cap on the size of projects. To do otherwise may be artificially restricting the highest and best uses of the grant funds.*

## Eligible Costs

**Administrative Expenses.** Because the primary focus of the program should be to fund infrastructure and not project administration, we propose three limits on administrative expenses. First, support for such expenses will be limited to 36 months, commencing with the first month in which the participant has been notified that its project is eligible for funding...Second, we propose that the rate of support will not exceed \$100,000 per year. This amount should be sufficient for one full-time employee (or the equivalent) dedicated to project administration...Third, we propose that the aggregate amount of support a project may receive for administrative expenses shall not exceed ten percent of the total budget for the project.

*While the NSTN Governing Committee applauds the FCC’s proposal to recognize administrative costs associated with complex projects such as the Health Infrastructure Program, we have concerns about both the length of time for which the funding is available as well as the concept and amount of the funding cap. Multi-million dollar, highly technical and planning/deployment intensive projects will require a level of expertise and a commitment of time that is likely to outgrow a \$100,000, 36-month cap. While it is understandable that infrastructure is the focus, infrastructure expenditures without appropriate planning and oversight will lead to failure. The NSTN Governing Committee instead suggests the FCC consider administration as a percentage of the overall award, thus allowing larger, more complex projects to be adequately administered. We believe that the long-term viability of the program carries a “greater good” than prospectively setting a limit on costs. Furthermore, it is not clear if the term “employee” implies that the grantee must employ the individual(s) responsible for administration of the project. Due to the level of expertise required, the best individual(s) may be outside consultants, thus administrative funding should cover the cost of either.*

## Ineligible Costs

*The NPRM lists many ineligible costs. The NSTN Governing Committee suggests that the FCC consider making legal costs fully or partially eligible, as well as allow funding for building technological redundancy into construction of the project. The investment in ensuring an appropriate legal structure for these projects contributes significantly to the development of long term success. Technological redundancy is necessary in reasonably providing a service that can reliably meet the needs of the desired users as well as remain functional in a public health disaster or emergency.*

## 15% Contributions Requirement

**Minimum Participant Contribution.** We proposed that as one of the conditions to receiving any funding commitments from USAC, participants submit certification of availability of funds, from eligible sources, for at least 15 percent of all eligible costs.

*The NSTN Governing Committee understands the Commission's interest in ensuring that each participant has a financial stake in the project; however, it is our understanding that many current FCC Pilot Program projects have expressed difficulty in providing the 15% and we would expect that this will remain a common issue among future potential applicants. The inability to provide a 15% financial stake in eligible costs does not necessarily directly correlate to decreased accountability in the project. Federal agencies routinely provide grants to successful, sustainable projects without requiring a financial match of any kind. The NSTN Governing Committee proposes that the Commission either allow waivers for projects that cannot provide such a match or allow in-kind, non-financial contributions.*

## II. General Comments Regarding the Rural Health Care Program

*The NSTN applauds the Commission's interest in expanding the definition of eligible providers. In states such as Nebraska where nearly half of the population resides in two counties and the other half are spread over 91 counties, the majority of which are medically underserved areas, local providers and specialists located in widely geographically disbursed areas are challenged to provide advanced, life-saving health care. As such, assisting in sustainability of telehealth technology through application of funding is essential to encourage adoption. As such, the NSTN Governing Committee supports the following:*

- ***Indefinite Grandfathering for sites previously deemed eligible under the 2004 rural definition.*** The NSTN Governing Committee, in comment to the Nebraska Public Service Commission's Petition for Permanent Grandfathering, thoroughly outlined the impact of the rural definition change on Nebraska and the ability to continue to function as a comprehensive statewide telehealth network with over 100 providers serving the rural population. Those previously eligible as rural prior to the definition change should be permanently grandfathered.
- ***Inclusion of Administrative Offices and Data Centers as detailed in the NPRM.***
- ***Support of Skilled Nursing Facilities (SNF).*** The NSTN supports and applauds the Commission's inclusion of this very vulnerable and immobile population; however, we would like to express our concern with the parameters posed in the NPRM. Suggestions in the NPRM include specific statistics regarding the percentage of beds or revenues from SNF patients to prove that the facility is primarily functioning as a SNF. We submit that

*the key indicator of need is not whether the primary population served in a facility is skilled, rather that skilled services are being provided. Using this as the criterion more appropriately recognizes that facilities include patients who would significantly benefit from the availability of telehealth services. In rural Nebraska, availability and accessibility of the skilled service is the most relevant measure of benefit to potential users of the service. We believe that limiting the eligibility to only those facilities that have a majority of patients classified as skilled artificially places a disadvantage to those patients utilizing skilled services in any facility. Additionally we would submit that if the proposed parameters are incorporated, the nature of these facilities dictates that the mix of patients may change frequently creating an issue with the reporting requirements of the proposed parameters in reporting periods. Perhaps a better solution would be to allow any facility licensed as a skilled nursing facility.*

- **Renal Dialysis Centers and Facilities.**
- **Additional Eligibility Considerations:**

**CMS Approved Providers.** *The NSTN encourages the Commission to consider allowing providers that are approved by CMS to provide clinical consultative services to patients via telehealth, whether urban or rural, to be included as eligible providers under rural health care funding programs. By aligning the two programs, telehealth can be more effectively deployed and adopted by those that can best serve patient populations.*

*We underscore the following as of special interest to the NSTN Governing Committee:*

**Urban Providers that Serve Rural Populations.** *Due to the predominantly rural nature of Nebraska and the fact that specialty providers are almost exclusively located in urban areas, it is extremely important that these specialty providers be eligible for funding support. These specialty providers serve not only as a rural health safety net through the provision of health care, but also provide leadership in collaborative ventures, education, training and information technology support to small rural health facilities and practitioners. They should be encouraged to provide services through eligibility for funding support.*

**Emergency Medical Services (EMS) and Emergency Medical Transport.** *The NSTN Governing Committee specifically requests that the Commission support eligibility of Emergency Medical Services providers, which play an essential role in the continuum of patient care starting in the field as well as allowing the Emergency Department Physician and staff to operate more effectively and efficiently in preparing for the patients' arrival. Nebraska, through a series of Federal grants, has been fortunate enough to be able to supply every hospital in Nebraska with telehealth capabilities in the Emergency Departments. This will provide invaluable feedback as to the return-on-investment in dollars saved and improved clinical outcomes of the trauma patient; EMS connection would allow this to be a more comprehensive system. In addition, also connecting to educational and administrative meetings via telehealth lines at the EMS station would allow more personnel to attend classes and participate in meetings, thus negating the need to travel to an area hospital or public health department that might be many miles away. In Nebraska, a state in which rural EMS is nearly exclusively volunteer, and, thus, subject to the willingness and time availability of those who serve in this role, reducing time and travel expenses may make the difference between retaining a volunteer and losing one.*

**Physician/Practitioner Offices.** *The specialists who are in high demand to provide services to rural patients are often already overburdened and over-scheduled. These providers not only manage their office practices but also hospital inpatient and outpatient populations. In addition many also often travel hundreds of miles to provide outreach clinics directly in rural communities. Some, such as dermatologists and licensed mental health providers, are so busy within their offices that they have little time to do any outreach even though the need is great. By allowing telehealth to be integrated directly into the practitioner office, the practitioner is more likely to be amenable to providing this service than if he/she had to carve time of the day to relocate to an eligible hospital to connect. Once located conveniently in the practitioner office, the telehealth patient becomes just another patient in an exam room and the physician can transition easily between the patient he/she is seeing “live” and the telehealth patient. For-profit status of the practitioner office should not preclude eligibility.*

- **Other**

**Application Process for Funding.** *The current Rural Health Care Program requires Health Care Providers (HCPs) to re-apply for funding each year even if the HCP has an evergreen, or multi-year, contract and has not made any changes to the contract since the initial filing. This process is burdensome to the HCP and must likely be burdensome to USAC, given the fact that it often takes months for funding to be applied to the HCP accounts each year. This results in additional wasted time tracking payments to assure appropriate credits have been received and increases the probability of an error in filing or application of funds. The NSTN Governing Committee suggests that a true evergreen provision be applied to those HCPs with multi-year contracts that would allow for a single application to be required at the beginning of the contract and not required again until the contract has expired and a new contract put into place with the winning bidder.*

**Allow Connectivity Between Health Care Providers and Libraries/Schools.** *The Commission currently funds both health care facilities and schools under separate funding mechanisms, yet while both are eligible for support they are not allowed to connect to one another without having to carve out funding support except for post-secondary educational institutions that provide continuing education to health care providers. The NSTN Governing Committee suggests that the Commission could experience cost-efficiencies in allowing education and health care networks to connect to one another and share common backbone lines, which would also allow for interactions that are beneficial to both. For example, many rural school districts are experiencing difficulty in attracting and paying school nurses, the interaction of health care facilities and providers with these schools could provide for real time surveillance and intervention in these school populations.*

## **Closing**

Once again, the NSTN Governing Committee thanks the Commission for the opportunity to comment on the Notice of Public Rulemaking and encourage continued interaction between the Commission and health care providers across the nation.

Respectfully Submitted,

The Nebraska Statewide Telehealth Network Governing Committee